NATIONAL ACADEMY *for* STATE HEALTH POLICY

The Patient-Centered Medical Home Model in State Medicaid Programs

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The Commonwealth Fund is funding a Taskforce for Implementation of the Patient-centered Medical Home Model in State Medicaid And SCHIP Programs

Why Focus on Improving Medical Homes in Medicaid/SCHIP now?

- Medicaid agencies have a long-standing interest in providing medical homes to program participants
- Circumstances are right for making major advances in Medicaid's implementation of medical homes
  - New opportunities
  - There are existing structures on which to build
  - State agencies already developing new models/approaches/strategies

Complementary Occurrences

- Creation of Patient-Centered Medical Home (PCMH) model and Patient Centered Primary Care Collaborative (PCPCC)
- NCQA: process and standards for assessing if practice functions as medical home
- Increase in use and usefulness of Health Information Technology—and Medicaid funding for HIT development

The Patient Centered Medical Home Model

- Agreed upon by 4 major primary care physician groups, large employers, health plans and others
- Establish and support primary care teams in providing comprehensive, patient-centered care
- Patient Centered Primary Care Collaborative (PCPCC) formed to support further model development and implementation
- NASHP partnering w/PCPCC to develop strategies and policies to implement in Medicaid and SCHIP (Medicaid Task Force)

The PCMH is defined by six principles

1. Ongoing relationship with personal physician
2. Physician directed medical practice (team approach)
3. Whole person orientation
   - Practice team provides or arranges for all health care
4. Coordinated/integrated care
   - Right care at right time across health system and community
   - Facilitated by registries, HIT/HIE, etc.
5. Quality and safety
   1. Practices demonstrate capabilities
   2. Patients & families in quality improvement activities at practice level
6. Enhanced access to care

Patient Centered Primary Care Collaborative

- Formed by supporters of PCMH model
  - Provides umbrella for providers, employers, plans and others to come together for purpose of facilitating adoption
  - Partnering with NASHP to develop models/strategies for implementing in Medicaid—PCCM and HMO
- Proposed ideal reimbursement model for **practices**
  - Payment for services
  - Care coordination payment recognize cost of acting as medical home
  - Performance-based incentive payment

Past efforts can support implementation of the patient-centered medical home (PCMH) model

Past efforts that can support new efforts

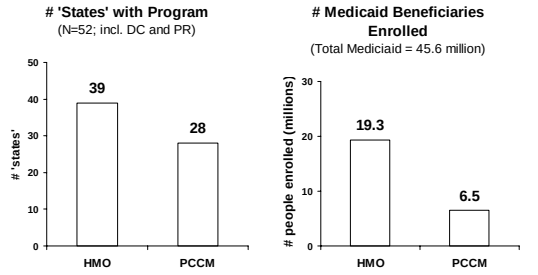
- Managed Care
- Disease Management
- Targeted Case Management and care coordination

How managed care can support PCMH model

- Delivery system/payment structure
  - PCCM programs (e.g., North Carolina)
  - Performance incentives for both HMOs and PCCM
- Quality improvement infrastructure
  - Measure performance
    - HEDIS, CAHPS, and others
  - Change plan and provider behavior
    - HMO programs required to contract with external quality review organizations and conduct performance improvement projects
    - Often by working with other stakeholders
    - Learning collaboratives in place in at least six states

Medicaid Use of HMO and PCCM, 2006

Source: CMS Medicaid Managed Care Enrollment Report



Changing managed care to support PCMH model

- How to implement model through HMO
  - Contract requirements?
  - Payment incentives?
- How to modify existing QI infrastructure to measure and support medical home performance
- Best ways to enhance standard PCCM model
  - Change common perception: not gatekeeper but home?
  - Change expectations of practices?
  - Change reimbursement: additional coordination fee, a la NC?
  - Create stronger connection to specialty care and disease management?
  - Better, more timely feedback on practice performance—tied to payment?

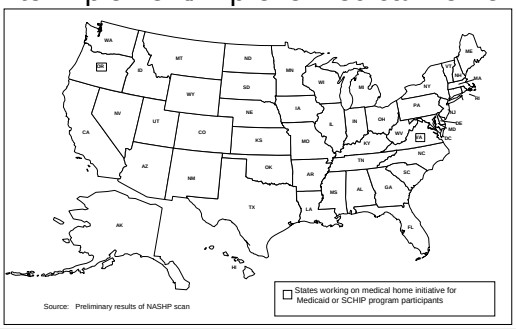
Disease Management

- In 2004, 22 state Medicaid agencies had disease management programs, most disease-specific
- By 2007, some moved toward approach envisioned in medical home model, more are interested
  - Connection to primary care: Indiana, Rhode Island
  - Population-based: Illinois, Indiana, Rhode Island, Vermont
  - Pay-for-performance: Illinois, Washington
  - One manager/multiple chronic diseases: Illinois, Indiana, Pennsylvania, Rhode Island, Vermont, Washington
- Big remaining hurdles
  - Very few connected to physician practice or PCCM program
  - Most still disease specific management model contracted to private company

Care coordination

- Many states cover Targeted Case Management for a defined group(s) of beneficiaries
- Care coordination is covered for all children under age 21 (EPSDT)
- Hurdles
  - Create better connection to primary care
  - Definition of allowable services in flux at federal level

Medicaid/SCHIP Programs Already Working to Implement/improve Medical Home



Source: Preliminary results of NASHP scan

Identified efforts vary widely

- Most starting w/children or subgroups of people w/complex needs
- Six have legislative authority/mandates for effort (CO, LA, MO, RI, WA, WV)
- Eight developing HIT to support practices (AL, AZ, HI, MN, OR, RI, WV, WI)
- Four working in conjunction with HMO model (AZ, TN, RI, WI)
- Two developing multi-payer initiative that includes Medicaid and Medicaid-contracted HMOs (RI, CO)

Strategies to support performance

- Examples of Information Technology for PCPs
  - AL: Interoperable EMR that combines information from physicians, hospitals, pharmacies, state immunization registry, labs, Medicaid pharmacy information; Pilots implemented-spreading statewide
  - LA: Provides access to state immunization database and rewards providers who access the information and achieve specified immunization performance
- Local care coordinators outside practice (AL, HI, RI)
- Providing PCCM fee to practice for performing functions (NC)
- Pay higher PCCM fee for enrollees w/more complex needs (IL, RI)

Strategies to incent performance

- Vary case management fee by PCP qualifications (AL, LA, MN, PA, RI)
  - Use of electronic medical records
  - Completion of CME
  - Past performance on providing immunizations
  - Enhanced access
- Share savings with PCCM providers (AL)
- Providing profiles of PCP performance compared to cohort (AL, IL)
- RI offers performance incentives to HMOs for performance relevant to effective medical home

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For More Information

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Patient Centered Primary Care Collaborative
www.pcpcc.net

NCQA-Patient Centered Medicaid Home
http://www.ncqa.org/tabid/631/Default.aspx